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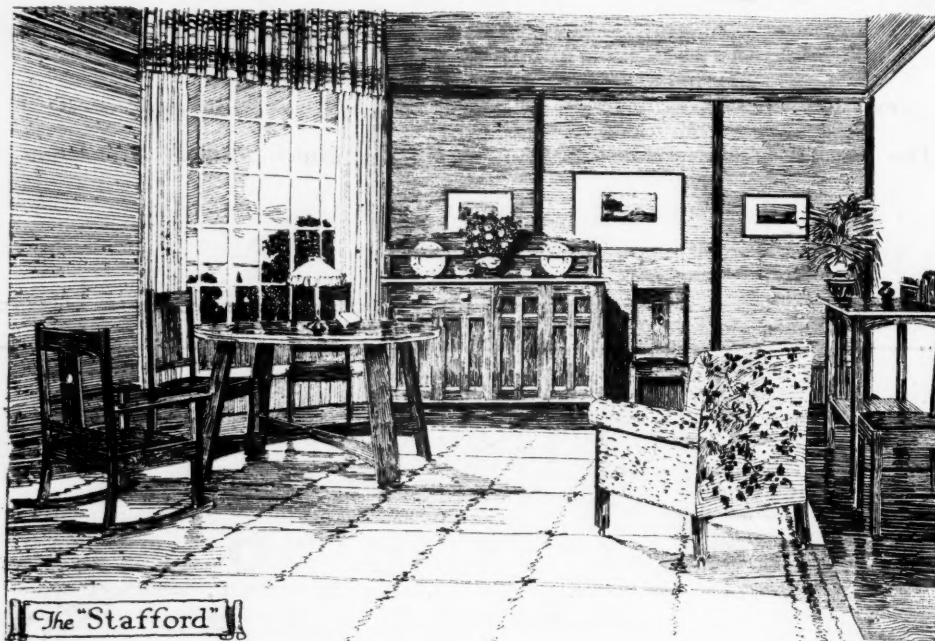
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HIGH FREQUENCY CURRENT IN COMPLICATED URETHRITIS.

By J. Cooper Booth, M.B., Ch.B. (Edin.),
Sydney.

The use of high frequency current in the treatment of complicated urethritis due to the gonococcus is not new, but is so little taken advantage of that these brief notes may perhaps serve to awaken interest in the subject.

The medical world is apt to look askance at high frequency work on account of the use made of it by advertising laymen and also on account of exaggerated statements which have been made regarding its curative powers.

I have found it of value in some cases of venereal disease when combined with routine treatment. It does not do good in all cases, but is a decided help in the majority of posterior urethral infections with complications.

The treated area becomes hyperæmic and is acted on by ozone which is produced by the electrical discharge. This favours oxidation. Infiltrated areas are softened and adhesions are slowly absorbed. Secretions are increased and the stimulated glands wash out some of the infected contents. The local action is germicidal.

The treatment may awaken a dormant gonorrhœal condition and give increase in the urethral discharge.

As regards the general effect there is a feeling of well being if the treatment extends over a number of days, due to the tonic effect of the current.

The high frequency generator I use is a portable one and with it I use four types of glass vacuum applicators: a surface one, two urethral and one rectal. The urethral and rectal types are insulated. The generator is adjusted to give 3 mm. spark for a mucous membrane and 6 to 12.5 mm. spark for a skin surface.

The period of treatment does not exceed six minutes for a mucous surface or ten minutes for a skin surface at a sitting.

The treatment is painless if the glass applicator is in close contact with the treated surface. When treating a mucous surface the applicator is placed in contact before the current is turned on, thus obviating shock.

The dangers are few. A burn is possible, a surface burn which may be rather slow in healing. A weak patient may be "shocked" and collapse. The violet rays from the type of applicator used will do no harm; I doubt if they have any appreciable therapeutic action.

The following are a few of the complications which may benefit by high frequency current: Prostatitis, vesiculitis, epididymitis, cystitis. It is of decided value in these cases. The treatment should be daily, if possible, for six minutes at a time. The rectal applicator is used. It is not advisable to use it on an abscessed prostate until the pus has been expressed by massage. The applicator is moved slowly from side to side over the prostate and vesicles. In epididymitis the affected area is also treated with the surface applicator for ten minutes daily.

Urethritis.—The urethral glass applicator is used for six minutes daily. Cases of litritis and infiltration are benefited. It is of little use in acute cases, but relieves the "scalding."

Adenitis.—It is of great value in inguinal adenitis where pus has not formed. If pus has collected it must be evacuated. The surface applicator is used for ten minutes daily over the affected glands. I have had some very satisfactory results in these cases. The skin is dusted with talc powder to allow the tube to slide over the skin without dragging.

Gonorrhoeal Rheumatism.—The surface applicator applied for ten minutes daily over the affected joint eases pain. Prostatic massage and the use of the rectal applicator, with intramine and, if necessary, vaccine are of greater use than local joint treatment, which only eases pain and does not attack the main seat of the trouble.

Nocturnal Emissions.—These cases benefit greatly by a course of treatment with the rectal applicator.

The uses of high frequency current, of course, range far beyond venereal diseases and non-venereal complications; it is in that wider field for others to work.

If high frequency treatment in venereal diseases is looked upon as but an extra weapon with which to fight, if miracles are not expected and cases are picked, I do not think that the results will be wholly disappointing.

A NOTE ON THE QUESTION OF HOOKWORM IN PIGS.

By P. A. Maplestone, M.B., B.S. (Melb.), D.T.M. (Liverpool).
(From the Australian Institute of Tropical Medicine, Townsville.)

Following the report in *The Medical Journal of Australia*, October 2, 1920, by F. W. O'Connor, on the finding of *Anchylostoma duodenale* in pigs in the Island of Funafuti, I have recently carried out a similar examination of pigs in the Townsville district. With the assistance of Mr. J. A. Rheuben, the Townsville Slaughtering Inspector, I have been enabled to examine and obtain records of 182 animals.

In 25 of this number the faeces alone were examined by the usual method employed in the examination of human excreta and all were negative for hookworm eggs. The remaining 157 were slaughtered and the duodenum and first part of the small intestine, with its contents, carefully inspected. No worms were found in any instance and the gut lining was perfectly healthy in every case, there being no signs that hookworms had ever been present.

The pigs came from the following districts, viz., Townsville, Ingham, Ayr and Charters Towers. With

the exception of Charters Towers, all these districts have been shown by the Rockefeller Foundation Hookworm Campaign staffs at present working in North Queensland, to contain hookworm-infected human beings. But the rate of infection is, in none of these places, approaching the rate of 91% found by O'Connor in Funafuti.

Although the number of pigs examined is too small to state definitely that this nematode does not occur at all in pigs in north Queensland, yet it seems justifiable to conclude that, at all events, pigs are not reservoirs for the worm in this area and that, with the present rate of infection, they are no danger from this point of view.

Another factor, besides the low rate of infection in human beings in the area under discussion, which lessens the danger of pigs becoming infected, is that the privies, disposal of night-soil, etc., although in many cases leaving much to be desired, are probably much better controlled than in a native population such as exists in Funafuti. Consequently, the chance of pigs gaining access to human faeces is much less and with the much lower infection rate in Australia than in Funafuti their chance of becoming infected with hookworm and propagating the disease among human beings is still more remote.

Conclusion.

On the evidence at present available, pigs are of no practical danger as factors in the spread of hookworm disease in north Queensland.

LECTURES ON MEDICAL ETHICS.

By A. V. M. Anderson, M.D., Ch.B. (Melb.),
Lecturer on Medical Ethics, University of Melbourne.

II.

Advertising.

When a young man enters upon private practice it is, of course, essential that he should have patients to treat; a very important part of medical ethics has to do with the restrictions which are placed upon a medical man in regard to his methods of attracting patients. In many businesses the regular and most satisfactory way seems to be that of advertising the advantages which result from business transacted with the advertiser. Such a course is forbidden to the medical man. Even in Australia, where there is an amount of laxity that would not be permitted in the United Kingdom, there are certain usages which must not be followed without fear of incurring the displeasure of the profession. On beginning practice a plate is usually put on the door to indicate the fact that the practitioner may be consulted within. It is not permitted to have numerous plates nor to have a name printed or painted in large flaring letters. In Harley Street, London, the small size and indistinct lettering of many of the numerous plates displayed are remarkable, but a reasonable thing is to have a plate bearing a name in legible lettering.

According to the regulations of the Victorian Branch of the British Medical Association no member, except with the approval of the Council con-

veyed to him in writing, shall have his name plate affixed elsewhere than (a) at his residence, (b) at premises where he attends regularly for the purpose of receiving his patients in the ordinary course of his practice.

In older countries, advertising in newspapers is not regarded as ethical. Here it is permitted within limits which are strictly defined by regulation of the British Medical Association. The general opinion of the profession is that such advertising is undesirable, but that as advertising is almost essential, particularly in sparsely populated districts, it is well that it should be regulated by definite rules to which members of the British Medical Association must conform.

These regulations are as follow:

1. (a) An announcement of commencement of practice shall take the following form:

Doctor (or Mr.) A.B. has commenced practice at _____.

- (b) An announcement of change of address shall take the following form:

Dr. (or Mr.) A.B. has changed his address from _____ to _____.

- (c) An announcement of resumption of practice shall take the following form:

Dr. (or Mr.) A.B. has resumed practice at _____.

2. Every such advertisement shall be "run on" without spacing and without display; the type shall be that ordinarily used for articles and not larger than that used for the leading articles of the newspaper in which it is inserted. No more space should be given to the advertisement than that required for printing the same; the name should be in the same type as the rest of the advertisement; letters or abbreviations, or words indicating medical, surgical, or other qualifications should not be added, nor the name of any qualifying body or university or college, nor shall any speciality be mentioned. Hours of consultation shall not be stated.

3. The number of insertions of any such advertisement shall not exceed six and such insertions shall be in consecutive issues of the paper.

In an announcement of change of address or commencement of practice the words: "In partnership with Dr. _____" or "As assistant to Dr. _____" may be added where appropriate.

It has been not uncommon, in country newspapers especially, for advertisements of this kind to be continued, usually without the consent or wish of the medical man, for long periods. Under such circumstances the medical man concerned should at once notify the proprietor of the paper that such advertisement must be discontinued.

If a medical man acquires a practice in a new neighbourhood, or is changing his residence, it is not unethical to circularize his own patients to that effect, but the circular must not be sent to anyone who is not strictly one of his patients. Even this practice is not regarded as desirable. Advertising a doctor's name as medical officer to any institution, run as a commercial venture, is not permissible. It is just as unethical for a practitioner to allow his name to be mentioned in biographical or other notices in the lay press. One fertile source of trouble consists in the mention of a medical man's name in connexion with the illness of some more or less distinguished person in the lay press. Such a practice should be discouraged or trouble may arise between the medical man and the ethical authorities.

The regulations of the Victorian Branch of the

British Medical Association require that no interview with a newspaper reporter on subjects relating to diseases and their treatment shall be given by any member engaged in active medical or surgical practice except with the following expressed stipulations:

- (a) That the identity of the medical man interviewed shall not be revealed in any report published of the interview.
- (b) That the name of the medical man interviewed shall not be published.
- (c) That a proof of the report for publication shall be submitted to the medical man interviewed for approval.

It is likewise unethical to give any testimonials to the usefulness of any trade article; if a practitioner writes to a medical journal about such an article, such writing should not be quoted in advertisements by the proprietor. If such advertisements do appear, action must be taken by the medical man concerned to have this advertisement withdrawn.

No medical man is allowed to advertise any of his writings in the lay press. If he delivers a lecture on any subject to a mixed professional and lay audience, he must make sure that such lecture may be delivered without any charge of an unethical character being brought against him. The regulation dealing with the question reads thus:

No public address or lecture or address or lecture addressed to a lay audience, or one liable to be advertised in any way, or published or reported in the lay press, shall be given on any professional subject by any member engaged in active medical or surgical practice except:

- (a) On the occasion of a public gathering organized by the medical profession.

(b) Under the auspices of the British Medical Association, the University of Melbourne, the Department of Public Health, the Royal Victorian Trained Nurses Association, the Royal Society or other scientific societies (recognized as such by the Council of the Victorian Branch of the British Medical Association), of which the lecturer is a member, or St. John's Ambulance Association or Australian Health Society.

- (c) Express sanction for the delivery of the same shall have been received from the Council.

If any breach of an ethical nature caused by a notice of any kind in a newspaper takes place, a letter to the editor of the publication pointing out the possible serious results of such action to the ethical disadvantage of the practitioner will usually be treated with respect.

The General Medical Council of Great Britain has issued a warning that advertising may render a medical practitioner liable to be charged with conduct infamous in a professional respect and, if found guilty, to have his name removed from the Medical Register.

Another procedure which merits professional condemnation is that of a medical man interesting himself in any business for the purpose of dealing in any instruments, drugs, food, etc., supposed to be of medical value. In the case of one well-known serum manufactured in what was lately an enemy country a celebrated medical man has come under unfavourable notice for patenting a remedy much used in the treatment of a common disease.

It is a recognized principle that a medical man should freely make public the benefits to be derived from the use of any of his discoveries.

Methods of Attracting Practice.

Canvassing for patients in any way is regarded as being just as reprehensible a practice as advertising directly or indirectly. This is more frequently a source of trouble in lodge than in private practice. In Melbourne there are associations which have as medical attendants men who are regarded as unethical practitioners, partly because of the fact that these associations employ as collectors and in other capacities men who endeavour to induce patients to leave their own medical men and put their names on the list of the doctor employed by the association. Such conduct is regarded as unethical and any medical man connected with any such association is not recognized by his fellow practitioners and will not be met in consultation by them. Similarly a medical man must not have any dealings with a society which takes up the treatment of patients as a commercial speculation for the profit of laymen.

It seems hardly necessary to mention the iniquity of a medical man either giving or receiving commission of any kind in respect to his patients, although it is whispered that such a condition of affairs is not wholly unknown. It must be a very rare thing for a medical man to pay commission to a layman who recommends a patient to him, but it is not an unknown thing for a person who is the means of introducing a patient to a doctor, to expect a *quid pro quo* in the form of some custom for his wares. One should keep oneself aloof from any suspicion of such a practice. Secret commissions are, of course, illegal. Even the appearance of complicity in such a transaction must be carefully avoided. The views of the profession on such conduct can be gathered from a resolution of the British Medical Association (April 12, 1899) according to which the giving or receiving of secret commission constitutes a grave breach of professional conduct and is inconsistent with membership of the British Medical Association.

The possibility of collusion between chemists and medical men is not beyond belief, the chemist recommending a certain doctor and the doctor in return requesting the patient to have the prescription made up by the recommending chemist. It has been said that some doctors give the patient a prescription which can be deciphered by one particular chemist only, to whom the patient is sent. Such practices are not only injudicious, but are unethical.

There is another practice somewhat allied which is said to be not uncommon. It is known as dichotomy; it consists in an operator who is recommended to a patient by his medical attendant, dividing the fee for the operation with that attendant. Such conduct is also reprehensible. A medical man should recommend as the specialist to be called in consultation the man whom he considers to be the most suitable and accessible and whose fees are within the means of the patient.

The Obligations of the Practitioner to His Patient.

It is of course essential that a medical student should use his best endeavours to become acquainted practically and theoretically with all the knowledge

possible of the profession he will have to practice. It is just as necessary after beginning practice that the medical man should continue his studies and keep in touch with all that is best in medical knowledge. One of the most attractive features of membership of the British Medical Association is that it provides for the weekly issue of the *British Medical Journal*, and of *The Medical Journal of Australia*. From these two sources he learns what is going on in the way of research and discovery here and abroad and also the position of the profession in the State and the relationship of its members to one another. He should also endeavour to attend regularly meetings of medical men at which medical matters are discussed and it is always well for medical men to keep in touch with some practical hospital or research work. I cannot help being impressed by the fact that some men seem never to have progressed since their student days. They have no new books and keep to the same methods of treatment as were in vogue when they were first qualified. It is true also that some men adopt the opposite tendency; they take up every new discovery and new method of treatment as if it were a veritable gospel truth. The couplet of Pope in his "Essay on Man" seems particularly appropriate in medical therapeutics—

"Be not the first by whom the new is tried,
Nor yet the last to lay the old aside."

At the beginning of your private practice you may feel that you are entitled to a fair share of leisure for recreation. This is certainly a necessity and at the same time you should have abundant leisure for increasing your knowledge; study of the science of your profession must be regarded as an ethical necessity. Having once got patients, it is fit and proper that the most careful investigation should be made of every case, even of those which are chronic and seem uninteresting. These should occasionally be reviewed and new light will often be thrown on what turns out to be a very interesting case. More errors of diagnosis are due to insufficient or imperfect observation than to want of knowledge.

Again to keep a firm grasp of your cases, note-taking of some kind is required, preferably by some card system. You will find as you get older that you cannot trust to your memory for details of a patient's former history. The taking of accurate notes at your first interview with a patient as well as subsequently will save you much time and the patient's estimation of you will increase when he sees that you appear "to understand his case thoroughly."

An occasional problem bordering on the ethical is how often should a patient be visited. In acute illnesses such as pneumonia or typhoid fever, and immediately after an operation patients should, of course, be seen daily or even more frequently. In less acute cases the frequency of the visit depends partly on your judgement and partly on the wishes of the patient. The patient is sometimes inclined to think that you are multiplying visits unnecessarily for the sake of the material advantage that will accrue to yourself. It is better to err generally in the way of not overdoing visits to patients. If frequent visits have to be paid, let the patient be satisfied

that they are desirable in the interests of his health. In lodge practice where the fees do not depend on the number of visits paid, you will meet with very little objections to fairly numerous calls. On the other hand you must not be led into paying unnecessary calls on patients who are not very ill, but who think themselves worse than they are. In every case satisfy your conscience as to the requirements of the case and act accordingly. So with lodge patients pay visits as often as you deem necessary, but be as careful in your attention to them as to your private patients.

Lodge Practice.

It may be as well to refer here to the general question of club or lodge practice which, as you know, has been bulking largely in professional as in public view lately. The original purpose of lodge practice was to provide efficient medical attendance for those members of the community on whom the ordinary fees of medical men would press hardly. It has always been regarded as applicable to those less well-to-do members of the community, the wage-earners, who find it difficult to put by money for emergency expenditure. During the past few years two points have become very obvious, namely (i.) that many people who are quite able to pay ordinary fees, join lodges largely with a view to getting medical attendance cheaply and (ii.) that although the cost of living has considerably increased, and medical men as well as the rest of the community have had to pay more for their commodities than formerly, the fees of medical officers of lodges have not increased. In fact they are in many cases less than they were thirty years ago, although the income of the wage-earners has considerably increased and the amount of attention (because of the greater occasion for clinical investigation) to be given to each patient is much more than formerly. It thus happens that, if they are to be properly attended, a smaller number of patients can be seen daily than used to be the case. Even before the dispute between medical men and lodges began in 1914 the lodge fees of medical officers were considered insufficient. This condition has since been accentuated because of the rapid rise of prices of all the necessities of life. It is therefore a simple matter of economic justice that these medical lodge fees should be increased; this fact has been recognized lately by the Royal Commission which sat in Victoria and the commission has also accepted the further fact that lodge practice is a concession which is not applicable to well-to-do people. The present trouble as to medical institutes is that a large number of medical officers of lodges who have made good their case for higher emoluments, have been displaced by medical men who have infringed the ethical rules of the Association. It is therefore unethical for members of the British Medical Association to meet these men in consultation.

If on entering upon a practice you feel inclined to become a medical officer of a lodge, it will be necessary that you should satisfy yourself as to the ethical nature of the agreement you will be called upon to make with the lodge. You should refer to the officers of the Victorian Branch of the British

Medical Association to see that your position is ethically correct. If you should start practice as an unethical practitioner, you will find your future endangered and your reputation with your fellow practitioners such that you will have the greatest difficulty in regaining their confidence and respect. For many young men starting in practice clubs seem desirable; they give a definite income; the practice is more readily transferred than is a private practice without lodges and is consequently more valuable as a selling asset. They also bring in a certain amount of additional work in the form of midwifery attendances, minor operations and attendance on the relatives of club patients. Still it is very necessary that no young medical man should bind himself to attend such patients under conditions unfavourable to himself and to his brother practitioners. It must be remembered that it is easy for a medical man to undercut his fellow practitioners in this way and to do a great deal of harm to them and to the profession generally.

Occasionally medical men make private arrangements with families to attend them at a certain rate *per annum*. According to the rules of the New South Wales Branch of the British Medical Association this is unethical, but no such embargo has been placed on the proposal in Victoria. If a fixed sum were paid yearly, the amount depending on the patient's income, and if there were a general agreement between medical men as to the rates to be paid and the services to be rendered, it seems to me it would be a desirable mode of arranging for medical attendance on persons of moderate means, who do not desire to become lodge members. The matter has been considered, but so far no decision has been reached. It would therefore be desirable for you to consult the Victorian Branch of the British Medical Association before entering on any such agreement.

It must always be remembered that a medical man can do only a certain amount of work daily and that in order to treat patients properly it is necessary to make proper clinical investigations in each case. It is therefore impossible to have under your care many patients at one time. Hurried work is inefficient and bad work. It cannot be expected that the attendance will be satisfactory when the fees received by the practitioner are so small and the number of patients seen so large that in order to make a living he cannot give proper consideration to each individual patient.

Fees.

As regards fees, you should have a copy of the fees approved of by the local medical societies. This schedule of fees has been held by Courts of Law to be reasonable. In cases where the circumstances of the patient are not good, especially if there has been a long attendance, some reduction of fees is frequently made, but it should be understood by the patient what your usual fees are and that a concession is being made in his case.

Fees vary somewhat according to locality; it is well to follow the usual custom of your medical neighbours in charging fees. Night visits are charged at a higher rate than day visits. You may expect to

be paid a consultation fee in cases where your services are called in consultation, even if you are not properly a consultant. In such a case it is not unusual for a modified fee to be charged by a general medical practitioner.

According to British law a fee is a gift from patient to doctor and once paid cannot legally be recovered on the ground of an overcharge having been made. Still it may be better to act conscientiously rather than legally if there should be any question about such a matter.

If you are sent for to see a patient and find on arrival that another practitioner has been called in, or for some other reason your services are not required, a fee is still payable to you as well as to the doctor who has already attended to the patient.

It is well to render accounts at regular intervals in the case of established patients quarterly or half-yearly, with occasional patients the sooner the better, when your attendance is finished.

If you see a patient on behalf of another practitioner, it is usual for the fee to be paid to him and not to you. If offered to you, it may be accepted and a settlement made with the medical man for whom you are acting.

It is not usual, but is not unethical, to sue for fees. It must be remembered that if an account is sent in to a patient, as it usually is, for the total of several attendances, the patient may ask for a detailed account, that is, for the separate items of attendance included in the account; such a demand must be complied with. The necessity therefore for a strict system of book-keeping is apparent and if you are unable or unwilling to do this yourself, it is well to have a competent book-keeper to do it for you. At first you will probably have plenty of time to keep your own accounts, but if you employ anyone else he should be as secret over your transactions as you are yourself.

It is remarked by Saundby that as the relation between medical man and patient is one of trust and not that of parties to a commercial transaction, medical men must be careful how they accept gifts from patients. It is easy for relatives to assert in the case of an insane or deceased patient that undue influence has been used in procuring this gift; a Court of Law may hold that such gifts are invalid and order them to be returned. A will, by which a large sum of money has been left to the medical attendant of a patient, has been set aside on the ground of undue influence, though the testator was of sound mind.

There are certain persons to whom accounts are not sent and from whom fees are not expected. As has been said medical men expect no remuneration for attendance upon brother practitioners, or their dependants. In some cases if a medical man has to travel a long distance he may be refunded his railway fare. It is not unusual for a medical patient to offer his attendant upon some small present and such an offer is a grateful acknowledgement of the services rendered. Medical men do not usually charge any fees to medical students or nurses; it is not a usual

thing to charge clergymen. When a clerical gentleman is in receipt of a good income, there seems to be no valid reason why he should not pay fees. Very often an offer to do so is made and accepted by his medical attendant.

A question that occasionally arises is as to the liability of employers for fees for services rendered by the medical man to an employee. The rule is that unless such attendance is rendered at the request of the employer, the patient himself or herself is liable for the payment of the fee. In Victoria as in England, there is a *Workmen's Compensation Act* which makes it the employer's duty to compensate a workman employed by him for any accident and in some cases for certain diseases arising during his employment. This does not make the employer responsible for the payment of fees for medical attendance. Occasionally in Australia and to a much greater extent in America firms employ medical men at a fixed annual sum to attend to the health of their employees. This system appears to be a good one and might be more generally followed here. If you are asked to undertake the treatment of employees under such conditions, it would be wise to make sure that the conditions, rates of remuneration, etc., are such as will be considered desirable from the ethical point of view by the British Medical Association and at the same time you should be very careful to follow the usual rules of ethics as regards attendance upon patients who are under the care of other medical men. Nothing must be done to alienate patients from their usual medical attendant.

Medical men are often appointed honorary medical officers to sporting clubs, such as football or racing clubs. This is contrary to the regulations of the Victorian Branch of the British Medical Association; any service rendered to a sporting club or similar body should be charged for and no appointment in an honorary capacity accepted.

Sometimes it happens that a medical man employed by an association, such as an accident insurance company, is asked to visit, examine and give a report to the company concerning the health of the injured or sick employee. In such cases the patient should, if possible, be seen with the attending medical man. If this is not feasible, as much care should be taken by the medical man who is examining, as where he was seeing a patient of a *confrère* to avoid expressing any opinion as to treatment and to exercise very great care if splints and dressings have to be removed. It is eminently desirable if this has to be done, that arrangements should be made for the attendance of the patient's own medical man.

In seeing patients who complain that certain symptoms have arisen as the result of an accident, the practitioner should bear in mind the possibility of straight out malingering or malingering by "exaggeration" or "continuation." The examination must be as complete and thorough as possible so that no injustice is done either to the patient or the employer. Any means of investigation, such as X-ray examination or special clinical investigation, necessary to insure a more exact diagnosis must be insisted upon before a report is given.

If you are attending an injured patient who is insured and a request is made by the accident insurance company for their own medical man to visit and examine the patient, such a request should always be granted. It is desirable in the interests of your patient that you should, if possible, be present at the examination to give the examiner the benefit of the result of your knowledge of the patient. Complaints are sometimes made by medical men that insurance referees have visited their patients in order to examine them for life insurance purposes. It is the usual custom that candidates for life insurance should visit the medical referee either at the rooms of the latter or at the office of the company. When a medical referee pays a visit to the patient's house for such examination, it is an act of courtesy for him to announce his intention to the ordinary medical attendant of the patient.

Hospital Practice.

The relation of medical men to hospitals is one that is the subject of many inquiries from the ethical point of view. Hitherto the ordinary public hospital has been regarded as a place where efficient treatment may be obtained by those members of the community who are not able to pay ordinary medical fees; for those who are able to pay the usual fees of a doctor, to make use of hospitals has been regarded as an abuse. Such abuses have been steadily growing and in some States the Government has insisted that the benefits of public hospital attendance should be open to all persons irrespective of their circumstances. This official attitude has been resented by the medical profession, especially by those of them who gratuitously give their services to general hospitals. The tendency of these Governments is towards nationalization of medical services. This question of nationalization of the medical profession is one which is likely to affect those of you who are just about to enter on practice. At present "nationalization" obtains to a certain extent, as in lunatic asylums or mental hospitals, examination of pupils in State schools, etc., but there are many politicians who will not be content until it becomes general. As you may know, a general scheme of medical insurance for wage-earners has come into existence in England and may do so eventually here; you should know something about the conditions in England and be ready to take an interest in the question if it arises here.

At most hospitals it is the rule for inquiries to be made by a member of the hospital lay staff into the circumstances of patients requiring assistance; if these inquiries are satisfactory, the patient gets all the benefit of the hospital service and is entitled to the best skill and attention of its medical officers. General hospitals are maintained partly by Government assistance and partly by the donation and subscriptions of the charitably disposed public. In a resolution of the Australasian Medical Congress held in Melbourne in 1908, it was recommended that no payment whatever should be taken from patients treated at hospitals which were maintained by the donations of the public and by Government grants. For many years past, however, the amount paid by patients in hospitals has been increasing and the managers of

the hospitals, often in view of the difficulty of financing their institutions, have been unwilling to do anything to diminish revenue obtained from patients. It is easy to see how patients who are paying something for their maintenance, consider that they are just getting a fair return for their payments and how the system may extend until a comparatively well-to-do patient thinks he is quite justified in getting the benefit of hospital treatment for a small donation or weekly payment. This is manifestly unjust to the honorary staff of the hospital. It is therefore not surprising that the system is reprobated by the medical profession. It is realized that in cases of emergency or accident hospital treatment may be utilized if it is the most accessible. Otherwise hospitals should be retained for those for whom they were originally intended. In Melbourne there is no doubt that the use of hospitals by the comparatively well off has inflicted great injury on the poorer people, who have been at times unable to obtain admission. It should be the duty of every medical man to see that the poorer classes of the community get the medical treatment which has been provided in hospitals for their benefit.

It is but right to say that in this State the Inspector of Charities is insistent upon the necessity for the abolition of this form of hospital abuse.

Difficulties arise when as in a neighbouring State the Government insists on the hospitals being open to the well-to-do. In Tasmania at the present time the ethical members of the profession have refused to have anything to do with this abuse of charity and consequently have withdrawn their assistance from the State hospitals. Some of you may be placed in the awkward position of having to sever your connexion with or to refuse to give your services to an institution under such conditions. Here again it is well to take the general sense of the ethical members of the profession as to the line of conduct which you should adopt.

It is not unusual for medical men to send a patient into a hospital for operative treatment or for treatment of a prolonged illness, or because the necessary nursing and attention cannot be obtained in his own home. In many such cases the patient is quite able to and ordinarily does pay his medical attendant a fee for a consultation or visit. If you are an honorary medical officer of a hospital and such a patient comes under your care in the hospital, you should obey the ordinary rules of ethics when the patient leaves the hospital and should refuse to attend him as your own private patient if requested to do so, just as you would if he had been referred to you for an opinion by his medical attendant.

A medical man whose patient is admitted to hospital, of course, relinquishes the treatment of the patient to the hospital physician or surgeon, but he naturally retains an interest in his former patient and should always be met courteously by the medical officers of the hospital if he make inquiries concerning the patient's welfare. It is usual for him to see the patient at times if he visits the hospital; no objection should be raised to this. Occasionally discourtesies on the part of young resident medical

officers to outside practitioners are experienced and are naturally much resented by older medical men.

When a patient is sent in by a medical man to hospital for operation, it is an act of courtesy, if it can be conveniently done, to inform the ordinary medical attendant of the time of operation, so that he may be present if he so desires; this procedure is a routine in some hospitals.

When you are resident in a hospital, your concern is mainly with the medical treatment of patients, but there is a large amount of administrative work that must be carried on by a lay staff. It is well to try and live in the most harmonious relations with your lay *confrères*, realizing that your objects are similar, although your spheres are different. What you consider as being in the best interests of the welfare of patients is not always consistent with economical administration. You will find at times that a good deal of prudence is required to make your position a satisfactory one. If any food, drug, or appliance is ordered by you, you should be able to show that it is a necessity for the proper medical treatment of your patient. You can often prove that what seems to be an extravagance is, because of the reduction of the time required for treatment, really an economy. As a junior resident medical officer of a hospital, always respect the authority of the medical superintendent or your honorary medical officer.

In order to have co-operation between the lay and medical side of hospital work it is wise that there should be representation of the medical staff on the managing lay committee. This co-operation is often attended with the happiest results.

It must be remembered that the patients in a hospital are entitled to as much consideration and courtesy as your own private patients. They are poor as well as ill and, as the medical man from the nature of his profession regards his function as that of giving relief without insisting on fee or reward, he can here indulge his professional predilections to their fullest extent. Among a certain class of the public the imputation has been made that hospital patients are sometimes the subjects of experiment. Such a charge has very little truth in it. It is the duty of everyone associated with hospital patients to see that nothing is done that would merit such a reproach. As much consideration too should be given to the friends and relatives of hospital patients as to those of private patients. It is true that they are sometimes prone to make themselves a source of trial to hospital doctors; but their natural anxiety should be remembered and everything done in reason to satisfy their desire for such information as can be given them.

Some patients in teaching hospitals complain that their feelings and best interests are at times subordinated to the desire to impart clinical instruction to medical students. Such a charge too has very little foundation. The careful investigation that has to be made under the watchful eyes of critical students is on the whole a good thing for the patient. Care must be taken to see that the health and modesty of the patient do not suffer from the carrying out of any means of investigation.

It is hardly necessary for me to dwell upon the great advantages that accrue to the young medical practitioner from the opportunities he has for the investigation and observation of hospital patients. It is as good for him as for them that the most punctilious attention be given to their ailments. Careful diagnosis and efficient treatment is not only of the greatest assistance in the doctor's education, but it also impresses the patient who sees and appreciates the care that is bestowed on him. Many a large medical practice has had its foundation in the devotion to duty of a young resident medical officer in the wards of a public hospital.

It is one of the recognized rules of public hospitals that no fee should be taken by medical officers from any patient under his care.

You will probably frequently meet in your private practice a patient who cannot pay ordinary fees for medical attendance or for a surgical operation, but who is unwilling to accept charity in a public institution. In these cases the provision of an intermediate hospital is of very great benefit and the advantages of such an institution are so evident that it is likely to constitute in future a much more important part of hospital work.

It may be interesting for you to know the resolutions of the Australasian Medical Congress regarding these hospitals which were approved of by the Congress in 1908. They are as follow:

- (i.) Intermediate hospitals shall be for patients who are ineligible for public hospitals, but who are unable to pay the customary fees, as well as the charges usually made in private hospitals.
- (ii.) There shall be no medical staff, but any medical man may send in patients and attend them.
- (iii.) The medical profession shall be adequately represented on the management.
- (iv.) No patient shall be admitted without first producing a certificate of suitability for admission from a medical practitioner, who should, whenever possible, be the patient's usual medical attendant. If the signatory be not the patient's usual medical attendant, an explanation of the fact should be appended to the certificate.
- (v.) There shall be no out-patients.
- (vi.) The same charge for maintenance shall be made to all patients in any one hospital.
- (vii.) The professional fees shall be arranged between the medical attendant and patient.
- (viii.) Touting for patients by advertisement or otherwise shall not be permitted.

It is understood that these hospitals should be used not by patients who are able to pay private hospital fees, lest an injustice be done to those private hospitals at which (as they are not training schools) higher salaries have to be paid to nurses. They are to be strictly for the treatment of the less well-to-do.

In some countries, especially in America, there is a combination in one institution of paying and non-paying patients, the former comprising people of all grades of ability to pay. It has been urged that provision should be made for such people in public hospitals. This is done in some parts of Western Australia and in some small country towns in Victoria where there is no scope for the establishment of a private hospital. Where a small cottage hospital is thus founded by charity or Government aid it is allowable to treat private patients in the wards of of this building. Care must be taken to see that no

injustice is done to the medical man who attends his patients by depriving him of his fee. In all cases where there is a combination of the two kinds of hospital, careful supervision is necessary in order that this purpose may be carried out. Here again the desirability of representation of the medical profession on the committee of management is evident.

Private hospitals have become increasingly numerous of late years and serve a very useful purpose. They are carried on usually by qualified and trained nurses as a commercial undertaking and are usually well run and can be availed of by medical practitioners. Sometimes, however, there are undesirable institutions of this kind under the control of an unqualified woman with no particular nursing attainments. You should beware of such establishments. Occasionally a hospital is run by a medical man who receives any profits accruing. This is an undesirable thing; it is considered that a medical man should not be personally interested in any commercial undertaking connected with the treatment of the sick. Such businesses should be left rather to qualified nurses.

ineffectively to deliver her—the presentation was a persistent occipito-posterior, impacted—I had to perform a pubiotomy hurriedly. I have terminated her three subsequent pregnancies at the 34th week, with satisfactory results, the infants weighing 3.6, 3.1 and 2.95 kilograms respectively at birth.

The first skiagram was taken eight weeks after the confinement. The second one was taken a fortnight ago with the aid of a Coolidge tube. It shows that the space which had been made available, has become soundly healed. Since the still-born child was delivered the patient has led a very active life and has played tennis well and without fatigue.

PRE-NATAL CRYING.

By **Milo W. Sprod, M.B., B.S.,**
Mannum, South Australia.

The following account of pre-natal crying, which occurred in my practice at Mannum, appears to be worthy of record:

Mrs. N., 4-para, was in heavy labour. On examination, I found the cervix fully dilated, but the head had not engaged the brim. The membranes were ruptured and a large amount of amniotic fluid gushed out. During this manoeuvre the patient was fully under chloroform preparatory to forceps extraction.

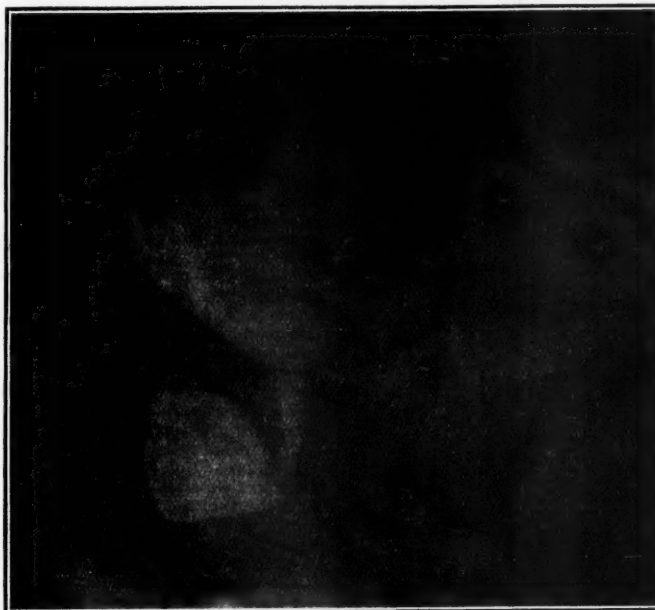
A few moments later, both the nurse and I were startled to hear three distinct cries, slightly muffled, as if under a blanket. Further examination showed that it was not an unexpected quick delivery. I immediately applied high forceps and delivered a blue baby with the cord around

the neck. The child began breathing after a little prompting.

Comment.

I have reported this case as I know that the phenomenon has repeatedly been ruled out as impossible, etc.. The explanation I would give is as follows:

- (1) A child with the cord loosely round the neck floated in an unusually large quantity of amniotic fluid.
- (2) On rupture of the membranes, a certain amount of air rushed in to replace the fluid.
- (3) The circulation was impeded through the somewhat short cord, as the uterus contracted down.



I.—Skiagram taken 8 weeks after confinement.



II.—Skiagram taken 5 1/2 years later.

Reports of Cases.

PUBIOTOMY.

By **J. W. Dunbar Hooper, M.D. (Durh.), L.R.C.P., L.R.C.S. (Ed.),**
Melbourne.

The first skiagram shows the ileo-pectineal line divided in a woman whom I delivered at term of a still-born child 5 1/2 years ago. The child weighed five kilograms. Having tried

Fortunately for the child, the patient had a well developed pelvis, etc., and a quick delivery could be effected.

Reviews.

INTUSSUSCEPTION.

In a preface to the second edition of his "Diagnosis and Treatment of Intussusception,"¹ the author, Dr. C. P. B. Clubbe, expresses the hope that the book may help both the young practitioner in his diagnosis and the young surgeon in his treatment of this condition. But even those who are not altogether unfamiliar with such cases, will welcome the re-publication of this monograph. For Dr. Clubbe writes as an acknowledged authority and from the wide experience gained during the past 27 years from the observation and treatment of 270 cases, the whole series showing an average mortality of but 20%.

In an introductory chapter the author preaches a sermon on the need for early diagnosis. "The death-rate for intussusception depends entirely upon the time (in hours) in which it is recognized after the onset of symptoms. If all cases could be diagnosed and dealt with in the early stage, the mortality would not, I suppose, be greater than that for the removal of the appendix in the quiet stage." His main objective is to indicate plainly the early signs and symptoms, to the end that the death-rate may be still further reduced. The statement is made that if all cases could reach the surgeon within twelve hours, the mortality would be almost nil.

In the chapter on symptoms and diagnosis emphasis is laid on the suddenness of onset and the fact that the clinical history is almost invariably "perfectly clear, straightforward and definite." The warning is given of the deceptively well appearance of the baby between the attacks of pain. The initial shock soon passes off and when the stage of sunken eyes, pinched features and collapse has arrived, the condition is a late and almost a hopeless one. The discovery of a tumour either on abdominal or rectal examination makes the diagnosis clear; if the examination be properly conducted this sign should rarely be missed. This all-important examination of a suspected intussusception is described at some length; the aid of an anaesthetic is held to be essential in many cases. In his long series Dr. Clubbe has only twice failed to palpate a tumour before operation and both were late cases with much distention.

The difficulty which at times occurs in distinguishing colitis and Henoch's purpura from intussusception, is discussed.

In the three chapters on treatment full consideration is given to the value of irrigation, particularly as an adjunct to laparotomy, to the conduct of an abdominal section and to the methods of dealing with gangrenous or irreducible bowel. These chapters are of exceptional interest. The author was successful in obtaining complete reduction in 10% of his first 140 cases by irrigation alone. He strongly combats the view that the method is either useless or in any way dangerous or shock-producing. Even when only a partial reduction is effected, he believes that this is of value, inasmuch as subsequent handling of the intestine is minimized. Moreover, since in almost every case the intussusception can be reduced to the region of the caecum, it may then be approached through a muscle-splitting incision instead of the usual mid-line or right rectus one. In the latter half of the series, Dr. Clubbe has proceeded at once to laparotomy with the happiest results, but it is evident that he considers it wise for the less experienced surgeon to employ a preliminary irrigation and to this opinion every consideration must be given.

Many practical points are embodied in these chapters on treatment and the final chapter on after-care. Among these are to be noted the advice that the incision should be free, the method of reducing the tumour through its varying stages, of dealing with prolapse of the intestines and the folly of removing the appendix without urgent cause.

Both during the operation and in the after-treatment

¹ The Diagnosis and Treatment of Intussusception, by Charles P. B. Clubbe, L.R.C.P., M.R.C.S. London: The Joint Committee of Henry Frowde, Hodder and Stoughton. Sydney: Angus & Robertson, Ltd.; Demy 8vo., pp. 91. Price, 7s. 6d. net.

every precaution is to be taken against shock, but subcutaneous injections of saline solution are considered undesirable, whilst morphine is usually inadvisable.

In the prevention of shock speed in operating and the least possible exposure of intestine are essential and the urgent need of such care might possibly have been even more strongly emphasized for the benefit of the young surgeon for whom this very valuable monograph has been in part compiled.

DERMATOLOGICAL DIAGNOSIS.

If the desideratum of Dr. J. F. Schamberg in his latest edition of "A Compend of Diseases of the Skin" is the condensation of current views of dermatological practice and the elimination of controversial matter, he has achieved success in this *multum in parvo*.¹ The classification, although closely following that of Duhring, nevertheless departs from this in several respects. For instance, he classifies *erythema scarlatinoides* in the inflammatory diseases in place of the hyperæmias, but on turning over to new growths the reader does not see exactly why he classes sporotrichosis and blastomycotic dermatitis in this section and actinomycosis amongst the inflammations. The desire to economize in space no doubt has induced the author to avoid a minute treatment of the classification of the higher fungi. Some mention should have been made of the epidermophytons, such as *Epidermophyton inguinale*, the etiological importance of which in the causation of *tinea cruris* is recognized by several authors, although it must be admitted that this, is of only academic interest and is outside the purpose for which the compend was written.

The absence of any mention of *ulcus molle* is remarkable. The same omission occurs in a large text book of dermatology recently published.

Although the author has found it impossible to give a detailed description of the various skin diseases and of their treatment, he has, however, devoted a chapter entirely to actino-therapy and has included a number of formulae which the reader will find most useful. This, together with the excellent differential diagnosis which the author, owing to his long and intimate association with dermatological practice, has been able to give with each disease, should make this small compend valuable both to the student and to the general practitioner.

THE WAR MEMORIAL FUND IN VICTORIA.

The following names were omitted from the list of subscribers to the War Memorial Fund published in our issue of last week:

John H. Anderson, S. O. Cowen, R. B. Perrins and E. Rogerson.

A further list will be published at a later date.

NEW ZEALAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Annual Conference.

The annual conference of the New Zealand Branch of the British Medical Association will be held in Wellington from February 27 to March 3, 1922. The Honorary Secretary is Dr. R. Campbell Begg, of 301 Willis Street, Wellington, New Zealand, to whom communications concerning the conference should be addressed. Committees have been appointed in connexion with the Section of Medicine, the Section of Surgery, the Section of Gynaecology and Obstetrics, the Section of Endocrinology and the Section of Pædiatrics. The last day for announcing papers to be read is September 30, 1921.

Dr. H. M. Jay and Dr. R. H. Puleine have consented to act as Members of the Board of Optical Registration under the *Opticians Act, 1920*.

¹ A Compend of Diseases of the Skin, by Jay Frank Schamberg, A.B., M.D.; Sixth Edition; 1920. Philadelphia: P. Blakiston's Son & Company; Crown 8vo., pp. 314, with 119 illustrations. Price, \$2.00 net.

The Medical Journal of Australia.

SATURDAY, JULY 9, 1921.

The Fascination of Field Work.

The humdrum task of endeavouring to ease a belly ache or of watching the progress of a mild attack of measles does not give promise of any real romance in medicine. But to a student of human nature and to the keen observer, even the average daily round of the general practitioner is made up of experiences and incidents compellingly enthralling. Many medical writers have dealt with special chapters in medicine in the spirit of romance and have presented to their readers real stories as exciting, as captivating as any fictionary legend. Medical practitioners are trained to read the wonderful book of Nature, not only when she deals with human beings in their infinite variety, but also when she treats of other living things, from the beasts in the field, the birds in the air and the fishes in the seas to the smallest and most elusive organism gifted with life. Little wonder that medicine offers so irresistible a charm to its votaries. While the ordinary vocation of the doctor may appeal to the majority largely on account of its rarities and because of the satisfaction attending the completion of a difficult diagnosis or the effecting of a cure of a serious disease, some of the special branches of a medical practitioner's activity must prove a continuous and veritable delight to him. Among the departments which hold the interest of every earnest worker unabated from the moment he enters, that of the field worker may be cited for particular mention. There is at the present time a powerful organization doing sterling work within every State of the Commonwealth, under the beneficent inspiration of the International Health Board of the Rockefeller Foundation. The Australian Hookworm Campaign has given to a handful of our young scientifically minded graduates an opportunity of tasting the sweets of a nature study of peculiar fascination. The tasks entrusted to these favoured men are varied and fertile. Essentially they are required to determine the incidence of anchylostomiasis in the

entire population of a defined area, to demonstrate the eradication of the infection in every person harbouring the worm, to educate the people to live healthy sanitary lives and to influence the local health authority to carry out its obligations to its charges. This work entails a careful study of men and women; the successful officer is he who grasps the psychology of individuals and crowds, who learns how to approach the indifferent to awaken enthusiasm in health. There is the scientific side of the work, the banishment of doubt in microscopical diagnosis and the exact evaluation of the relation between pathological processes and clinical manifestations. The medical officer is ever on the move, delving into new fields of research, coming into contact with new people and new districts. Nature's book is curiously open to him and the pages are turned for him as rapidly as he may will. He is given opportunities to trace out endemic and epidemic diseases among the communities placed under his charge. He has but to open his eyes and sharpen his wits to capture new species of intestinal parasites. In the field he can find insects, mosquitoes, flies, ticks and many others that have been passed by unnoticed since the white man penetrated into the vastness of Australia's fair plains and hills and vales. His opportunities are limited only by his own energy and the fact that the day has but twenty-four hours. It may be said that the measure of his interest in this unique sport is the measure of his ability to use his intelligence and his senses.

We have recently received from the Director of the Campaign a report by Dr. S. M. Lambert on the survey in Papua. This publication contains proof of the claim that field work has so strong a fascination for students of Nature as to rival almost every other sphere of science. Dr. Lambert tells his story well; the reader's inclination is to pack his suit case and take the next ship to New Guinea. There is undoubted romance in its pages. Who can learn unmoved of the utilization of Motuan natives to carry the most modern of preventive medicine right into the camps of tribes hitherto renowned for their predilection for a human meal? Who can picture the charm of a hygiene expedition through the marvellous Papuan territory without feeling a great impulse to wed his own daily work to adventure of this kind?

Of all the advertisements for the work of the field medical officer, that of the kind Dr. Lambert has unconsciously sent forth, is surely the most alluring.

The Hookworm Campaign is now seeking additional medical officers. The candidates must be young, healthy and energetic. They must be seekers after truth, keen to learn, able to use their eyes, ears, hands and brains. Special training will be given to suit them for some or all of the many phases of the work. There is opportunity for men with these qualifications, opportunities almost without limit. We appeal to young graduates with ambition to present themselves for this important national work. The conditions attaching to the appointments have been detailed in an advertisement which appeared in this *Journal* on June 25, 1921. Further information will be gladly given to anyone desiring it on application to this *Journal*. Good men are wanted.

SO-CALLED ACIDOSIS IN DIABETES.

In diabetes there is under certain circumstances an incomplete oxidation of fatty acids with the result that increased quantities of aceto-acetic and β oxybutyric acids are excreted in the urine. The failure of the pancreatic ferments to effect a complete disintegration of the fatty acids probably depends on a mechanism similar to that involved in the defective dissociation of the carbo-hydrate molecule. While much has still to be learned concerning the physico-chemical processes arising from the essential lesions of the pancreas in diabetes, valuable information is available concerning the acid-base excretion in the urine from which the significance of the excessive production of these acid radicals can be estimated. In order to obtain a clear conception of the disturbance in the chemical processes within the body, it is first of all necessary to recognize that an acidosis in the true sense of the term does not exist save in extreme cases. When an extra amount of acid radicals is poured into the blood the bicarbonate of soda is attacked and a neutral salt is formed. The liberated carbonic acid is excreted through the expired air. It will therefore be found that the hydrogen ion concentration of the blood remains unaltered. It has further been found that certain tissues appear to possess an elective affinity for the acid radicals of incomplete oxidation of the fatty acids and that these acid radicals are satisfied with bases in these tissues. This process would therefore lead to a gradual impoverishment of the body of fixed alkaline salts. But in spite of this drain no actual acidosis, no appearance of an increased hydrogen ion concentration in the blood occurs. It has been suggested that a measure of the degree of acid-base disturbance can be gained by the determination of the bicarbonate content of the blood. But the process is much more

complicated than this and consequently a more elaborate analysis of the blood would be required before the clinician could ascertain the actual fate of the fatty acids within the organism. It is possible to gain information indicating the ultimate fate of a proportion of the acid radicals from a careful analysis of the urine. Sellard pointed out some time ago that in order to estimate the extent of the encroachment on the alkali reserve, it is necessary not only to measure the acid-base excretion in the urine and the alveolar carbon dioxide pressure, but also to determine the effect of the ingestion of alkali on the acid-base excretion. It is a well-known fact that normal individuals excrete quite small amounts of sodium bicarbonate given by mouth within a very short time. Large amounts can be given to a diabetic before the reaction of the urine is altered. The clinician treating a patient with diabetes must recognize that the reaction of the urine is a complicated one and that he is likely to be misled if he endeavours to measure it by titration against one ordinary indicator. To ascertain the relation of acid and base radicals it is necessary to determine the ratio between the monobasic and the dibasic phosphate and the ratio of the nitrogen in ammonia to the total nitrogen. From these figures and from those of the titratable acidity the total acidity and the total fixed alkali can be ascertained. But even when the acid-base output has been determined, it is essential to study the effect of variations in the volume of urine excreted, of the ingestion of acid or alkali producing substances and of physical conditions influencing the metabolism. Some information has recently been added to our knowledge by Dr. E. G. B. Calvert, Dr. E. B. C. Mayrs and Dr. T. H. Milroy, all of the Queen's University, Belfast.¹ These physiological investigators started with the determination of the acid-base output in normal individuals both when the excretion of urine was restricted to a minimum by water and food starvation and when diuresis was produced by the repeated drinking of water. They found that the excretion of alkali is increased in diuresis in the normal individual, although the alterations in volume of urine are usually greater than the changes in the alkali excretion. Diuresis tends to alter the reaction of the urine toward alkalinity, while the nitrogen excreted as ammonia is reduced. But when the observations were transferred to a diabetic subject, it was found under the conditions of mild so-called diabetic acidosis that the abnormal acid production sufficed to prevent the increase of alkali during diuresis. The total alkali output was raised to a slight extent, while the ratio of monobasic to dibasic phosphate remained practically unaltered. It was further found that the total carbon dioxide capacity of the plasma was very slightly lower than the lower normal value.

When the normal person is given sodium citrate, there is a very slightly increased excretion of urine, containing a diminished amount of monobasic phosphate. The ammonia-nitrogen is also lessened. The total acid output falls as the alkali rises. When sodium bicarbonate is given these effects are more marked. During the first hour there is merely a

¹ *Journal of Pathology and Bacteriology*, January, 1921.

slight accentuation of the normal so-called alkaline tide. By the end of the third hour after the ingestion, the acidity has reached a very low level. In the diabetic with increased output of aceto-acetic acid and β oxybutyric acid, the monobasic phosphate decreases but slightly. This is to a small extent caused by a considerable diuresis. The so-called alkaline tide does not appear in the diabetic. The fall in the ammonia nitrogen corresponds closely to the fall in the monobasic phosphate and is little marked. Further experiment elicited the fact that large doses of both citrate and bicarbonate were required to influence the reaction of the diabetic urine and the ammonia excretion. Moreover, it appears that the ammonia excretion is affected before the reduction in monobasic phosphate begins. Dr. Calvert and his co-workers suggest that when a dose of bicarbonate sufficiently large to reduce the acidity of a diabetic urine is given, the body makes an effort first of all to spare the production of ammonia. Later, after the acidity of the urine is decreased, there is a distinct increase in the excretion of acetone bodies and especially of β oxybutyric acid. They hold the opinion that the greater part of the alkali is used to neutralize the abnormal acids at the sites of their production. The salts are not readily removed from these situations. They also point out that β oxybutyric acid claims almost all the available carbonate for its base, while aceto-acetic acid has a much weaker avidity. Observations on the alkali retention reveal that during sleep the normal person exhibits a condition akin to this so-called acidosis of diabetes.

CARBON MONOXIDE POISONING.

The subject of poisoning by carbonic oxide is always of interest even to those who have had the barest privilege of a scientific training. The mysterious gas with the simple formula which lurks in the "white damp" of mines and is capable of destroying human life, seized the imagination of the scientist when he was yet a tyro at school. The impression made on his plastic mind then loses little of its fascination now. For the miner the subject had up to recent times a more dreadful, if a less poetic, significance. That terror has now been largely eliminated, for with improved ventilation of mines, limitation of fire areas and prevention of explosions in mines the risk of carbon monoxide poisoning has been reduced to a minimum. Exposure to the gas in mines usually occurs about smouldering fire areas, after mine explosions or serious fires and after blasting operations. If present in the atmosphere to the extent of 0.2 vol. % there is serious danger to life, but symptoms of mild poisoning have occurred when the percentage was ten times less. With a view to the solution of the industrial problems concerned with this subject, Dr. Henry S. Forbes,¹ of the Harvard Medical School, has made an extensive survey of metal mines, coal mines, blast furnaces and producer gas boilers and engine rooms in the chief industrial centres of the United States. The study not only embraced a survey of medical records and an in-

spection of the surroundings and conditions of work, but also included the collection of information from official bureaux, mine officials, superintendents, foremen and individual miners.

Acute carbonic oxide poisoning usually begins with dizziness and frontal headache, followed by weakness of the legs, nausea, vomiting, asthenia, inability to stand and finally unconsciousness. The severity of the symptoms depend on the concentration of carbonic oxide in the atmosphere, on the duration of exposure and on the susceptibility of the individual. Men of neurotic temperament and those who suffer from pre-existent pulmonary and cardiac diseases, suffer most. Death seldom occurred. Dr. Forbes found that quick recovery under treatment was the rule and that sequelae and complications were rare. Headache, fatigue and muscle pains lasted a few days, but the patient was soon fit to resume work. Mine doctors, foremen and miners were almost unanimous in claiming that they knew of no men permanently incapacitated after gassing. Chronic carbonic oxide poisoning occurs in mines in which the men are exposed to "white damp" at frequent intervals for months. Headache and lassitude are the result, but a day or two off from work suffice to dispel these symptoms. Tolerance to the gas gradually develops as was observed by Haldane many years ago. Complications are rare and in several men who complained of poor health following gassing, the suspicion of some independent cause was strong. Blood counts revealed the absence of anaemia and a strong tendency to polycythemia. Careful red cell counts made on sixty-eight blast furnace workers showed the presence of 5,500,000 to 9,600,000 erythrocytes in each cubic millimetre of blood. In two-thirds of these men the count exceeded 6,000,000. Nervous symptoms, neuritis, paralysis and mental deficiency following exposure to the gas were unknown, although popular fancy has credited carbon monoxide poisoning with these complications.

The treatment of serious acute poisoning has been placed on a satisfactory basis, thanks to the researches of Haldane and Henderson. The affinity of carbonic oxide for haemoglobin is much stronger than that of oxygen, but the reaction is fortunately reversible. The breathing of oxygen or fresh air causes molecules of oxygen to displace molecules of carbonic oxide at a rate which depends on the partial pressures of the two gases in the alveolar spaces. Haldane and Henderson have deprecated the use of venesection and blood transfusion which have generally been recommended. It has been found that if a small percentage of carbon dioxide is administered with the oxygen, the change from carboxyhaemoglobin to oxyhaemoglobin takes place at a rate three to four times faster than when no carbon dioxide is used. This procedure is now being generally used. The use of respirators has also lowered considerably the incidence of carbon monoxide poisoning.

The information which Dr. Forbes has collected, will do much to dissipate the fears of carbonic oxide poisoning in large industrial centres. The comparative immunity of the miner from this affection is a tribute to the virtue of scientific and hygienic prevention.

¹ *The Journal of Industrial Hygiene*, May, 1921.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(16) The Application of Cutaneous Sensitization to Diseases of the Skin.

M. F. Engman and W. G. Wander (*Archives of Dermat. and Syphilis*, March, 1921) deal with the question of cutaneous sensitization in connexion with diseases of the skin. Chandler Walker is responsible for the grouping of proteins with regard to the practicability of determining sensitization. The authors have studied several diseases including urticaria, *erythema multiforme*, *lichen urticatus*, *purpura hæmorrhagica* and a large eczema group. The method of procedure was as follows: A detailed history is taken in each case, duration of the eruption, climatic conditions, occupations, seasonal variations and diet, with the object of finding definite instances of positive sensitization. Failing this, the proteins of beef, pork, eggs, wheat, milk and other substances are tested, especially those that are likely to play an ætiological rôle. The arm is cleaned and prepared half an hour before the test; a small incision is made through the epidermis on the inner side of the forearm. The incisions are placed 2.5 cm. apart and moistened with decinormal sodium hydroxide solution to which a small quantity of the protein preparation to be tested has been added immediately before the test. Of the eleven different diseases tested, two seem to have shown very definite results, *viz.*, urticaria (in fifteen out of nineteen a reaction was obtained) and eczema. The results in these two diseases were very definite, especially in the class of infantile eczema, which yielded excellent results under proper control.

(17) Glanders.

F. H. Jacobs reports a case of glanders in which the lesion occurred on the forearm (*Brit. Journ. of Dermat. and Syph.*, February, 1921). The patient had milked a cow with discharging sores on its udder. The man who had previously milked the cow, had had similar sores on his arm which had healed up without further recurrence. In the case recorded the primary lesion was quickly followed by others involving particularly the limbs and trunk. The condition was characterized by exacerbations and remissions till the time of the death of the patient. The lesion appeared primarily as a small pustule which quickly became indurated and spread to the size of a shilling in 24 hours. It continued to increase in circumference, while the centre became pale and assumed a normal appearance. This phase lasted for about a week; the eruption then faded away, only to reappear on the same or some different site and to go through the same evolutions as before. Six months

later the patient showed extensive involvement of the throat, tonsil and soft palate, causing deep ulceration and leading to considerable destruction of the soft parts. There was no adenitis and the general condition was not seriously impaired. His temperature rose from 38° C. to 38.9° C. The patient was again admitted to hospital six months later on account of a recurrence of the condition in the mouth which developed into *cancrem oris*. He died a few days later. The diagnosis was based on careful bacteriological investigations and the author appends excellent photographic and other illustrations in support of it.

(18) Dermatobia Hominis Infections.

Thomas McGrath has reported in the *Archives of Dermatology and Syphilis*, December, 1920, several cases of infection by the larva of *Dermatobia hominis*. According to the author the period from the time of infection to the time when medical aid is sought seems to vary. One particular case was that of a young man who had gone to live in Panama. He had been there about a week when he noticed a sensation in one shoulder similar to that of a pin prick. This was followed a week later by the appearance of a painful boil which gradually increased to the size of a carbuncle. Suppuration ensued and the larva of *Dermatobia hominis* was isolated from the pus. Other lesions similar to the first appeared later, in each of which the parasite was present. Several other cases in which the period of incubation varied from one to six weeks, have been reported from Panama. The great majority of the patients were travellers whose term of residence in Panama was limited. A mosquito of the genus *Psorophora* has been credited with being the carrier during its life cycle, but the author shows that the tick *Amblyomma cajennense* may also act as carrier. If not subjected to interference, the larvæ remain in the skin until an abscess forms. A larva is then thrown out. It drops to the ground, pupates and finally develops into the *imago* (the adult fly is known as the gadfly). The larvæ have been found in the flesh of many animals, including cattle, pigs, dogs, mules and man.

(19) Treatment of Severe Epidermophyton Infections.

Richard Weiss (*Arch. of Dermat. and Syph.*, April, 1921) reports that in cases of epidermophyton infection of the toes associated with secondary infection by pus organisms and maceration of skin, a saturated solution of picric acid is in many cases curative. With dry lesions, however, the results are not good. He recommends that the picric acid be applied on cotton wool and left in contact with the lesion. The lesion should be saturated with picric acid three times daily. The treatment should not be continued for more than a week. When cure is delayed Whitfield's ointment should be applied after treatment with picric acid.

(20) Digestion of Keloids.

Edward Ahlswede (*Archives of Dermat. and Syph.*, February and May, 1921), following the example of Unna, has carried out a series of experiments with a pepsin-hydrochloric acid solution. He has used it as a means of digesting the fibrous tissue of keloids and similar conditions and as a vehicle for the carriage of other chemicals through the horny layer of the epidermis. His experiments were, in the first instance, directed to the treatment of keloids, the solution used containing pepsin, 10 c.cm.; muriatic acid, 1 c.cm.; phenol, 1 c.cm.; and distilled water, 8 c.cm.. The phenol was added to prevent putrefaction. Four different methods of applying the solution were used, *viz.*, compresses, injections, ointments and guttaplaster. A 5% aqueous solution is the strength used for the compresses. The author claims that excellent cosmetic results follow the digestion of keloids, of scars from burns and of cicatrices. In some instances the application caused a slight superficial irritation of the skin. Hydrochloric acid was the responsible constituent, but this complication could be avoided by substituting 4% boric acid. The result, however, was not as good when boric acid was used. The pepsin-hydrochloric acid compresses are covered with impermeable material and the dressings are renewed daily until the horny layer covering the keloid is absorbed and the surface begins to ooze. A zinc gelatine covering is then applied until the horny layer is restored. The author states that chronic acne responds well to this treatment.

(21) Ichthyosis Hystrix Nigricans.

A. R. Hollender (*Urologic and Cutaneous Review*, March, 1921) has written on the subject of *ichthyosis hystrix* and especially on those forms of the disease in which there is a generalized pigmented keratosis. Because of this latter condition he suggests the addition of the adjective *nigricans* in the description of this form. *Ichthyosis hystrix* is a congenital condition marked by a dry, scaly and pigmented state of the skin. There is defective action of the sweat and sebaceous glands. Practically all cases are complicated by the presence of secondary eczema or of impetigo and by severe pruritus. The patients are thin and ill-developed, of low mentality but of normal habits. The best treatment is the use of frequent hot alkaline baths and inunction of the skin with ointments or pastes. The extreme cases of the disease are intractable.

RADIOLOGY.

(22) Lesions of the Right Lower Abdomen.

Baetjer and Friedenwald discuss the Röntgenological aspects of lesions of the right lower quadrant of the abdomen (*Amer. Journ. Med. Sciences*, November, 1920). For their examinations the authors use both opaque meals and enemata. The enema is suspended in

mucilage and is injected while the patient is in the knee-chest position. When acute appendicitis is the clinical diagnosis, an examination is invariably made of the chest, to exclude the presence of a basal pneumonia, which may simulate the abdominal condition. In cases of chronic appendicitis, the appendix may often be rendered visible and its size, position, shape, degree of fixation and tenderness on palpation noted. The appendix is usually filled in from 6 to 24 hours, and if it retains bismuth after 48 hours the disease process is generally a grave one. Failure to visualize the appendix does not exclude the diagnosis of appendicitis, as the lumen may be blocked or the organ may be retro-caecal. The diagnosis between duodenal ulcer and appendicitis is often very difficult and close study of the duodenal cap is necessary for differentiation. Incompetency of the ileo-caecal valve and ileal stasis are present when an examination after 24 hours shows the ileum empty, even if 12 hours later some of the meal has passed back into the ileum. If an enema is administered, it will be found to pass through the ileo-caecal valve into the terminal ileum. Caecal dilatation and retention may be diagnosed if a dilated caecum is found, with retention at the end of 48 hours. The patient may not suffer from constipation, yet the meal will remain in the caecum more than 60 hours, apparently clinging to the wall of the caecum and allowing a small passage for the food through its central portion. Angulations and kinks may generally be detected by Röntgenological examination and may cause varying degrees of obstruction to the caecum and terminal ileum. Acute tubercular ulcerations cannot be detected, but chronic forms show extreme hypermotility, especially of the caecum and ascending colon, with spastic contraction of the bowel and perhaps some irregularity of contour. In addition, an associated pulmonary tuberculosis is usually present. Carcinoma produces definite filling defects, which are constant at all examinations, and the patient complains of tenderness on palpation over the areas involved. Enemata are of most value in the diagnosis of carcinoma and an opinion should only be given after repeated examinations. In conclusion, the writers insist on the correlation of the clinical and Röntgenological signs and when the latter are diametrically opposed to the former it is safer to follow the clinical findings.

(23) Effect of the Cellular Reaction Induced by X-rays on Cancer Grafts.

Murphy, Hussey, Nakahara and Sturm subjected small areas of the skin in the groin of mice to an erythema dose of X-rays and a week later inoculated a cancer graft intracutaneously into the area. At the same time they inoculated a like graft in the same manner in the opposite groin, which was protected from X-rays (*Journal of Experimental Medicine*, March 1, 1921). The graft in the area

subjected to X-rays showed a low percentage of "takes," while that in the normal skin gave the usual high percentage. When the graft was introduced into the subcutaneous tissues it grew equally as well in the X-rayed area as in the protected area. Histological examination shows the skin layers, a few days after X-ray treatment, to be markedly infiltrated with round cells of the lymphoid type. The reaction did not spread deeper than the skin layers. It is suggested that this local lymphoid reaction induced by the X-rays controls the graft made into the skin, while its absence in deeper tissues accounts for the growth of the grafts more deeply implanted.

(24) X-Ray Therapy.

C. Thurstan Holland has reviewed the general use of X-rays in the treatment of various affections (*Archives of Radiology and Electrotherapy*, December, 1920). He deals with certain lesions which are benefited by radiation, such as ringworm, hyperhidrosis and *pruritus ani*. In the treatment of ringworm he follows the Klenboch-Adamson method of epilation of the scalp but in the other two conditions he uses small repeated doses. Exophthalmic goitre has responded rapidly to treatment by X-rays, but this treatment should be given simultaneously with the usual medicinal treatment and the patient should be kept at rest. Treatment must be carried out for many months and should be begun with small doses given three or four times a week. The interval should be gradually increased. The pulse rate, nervous symptoms and tremor show rapid improvement while the patient states that she feels greatly improved in health. When the disease is early the response to treatment is more rapid and there is little risk of producing myxoedema. Parenchymatous goitre is not benefited by radiation. Tuberculous glands, Hodgkin's disease and splenic leukaemia benefit greatly but in the case of leukaemia a recurrence is inevitable. Uterine fibroids are only treated by the author when the patient is over forty years, but in these cases he has reported great improvement in the symptoms and signs. Malignant disease should not receive radiation until it has been decided that operation is impossible; inoperable and recurrent growths should be vigorously attacked and care should be taken not to give too small a dose since such treatment only stimulates malignant growth.

(25) Pelvic Pneumo-Peritoneum.

J. van Zwalenburg and R. Peterson describe the technique of the operation of artificial pneumo-peritoneum for the examination of the pelvic organs (*American Journal of Roentgenology*, January, 1921). Carbon dioxide is used instead of oxygen as it is found to cause less distress during absorption after the examination. The carbon dioxide is led from an ordinary container to an ordinary rubber gas bag which is connected to a small

needle by means of a rubber tube. No manometers or washing apparatus are necessary. The operator pushes the needle through the abdominal wall about 3 cm. below the umbilicus, taking care to avoid any old operation scars. During inflation the bag is gently pressed between the knees of an assistant and a constant pressure is thus maintained. One to one and a half litres of gas suffice and if the patient is placed in the knee-chest position, the intestines are displaced towards the diaphragm and the pelvic organs may be examined on the fluorescent screen or may be skilgraphed. Many cases are quoted and some excellent skiagrams illustrate the usefulness of this method.

(26) X-rays in the Treatment of Malignant Disease.

Henry A. Chaplin (*Illinois Medical Journal*, March, 1921) discusses the use of X-rays in the treatment of malignant disease. He pleads for the use of all known therapeutic measures in the treatment of malignant disease, including surgery, radiation and electrocoagulation. In the past there has been a tendency to refer only patients who suffer from hopeless and inoperable malignant disease, to the radiologist and in these cases radiotherapy has often failed and become discredited. Removal of portions of the growth for microscopic examination leads to early dissemination. Such examinations should only be made when the surgeon is prepared to proceed immediately with the operation or to submit the area immediately to intense radiation. Metastasis in bone is common, but is very uncommon in brain and muscle. Malignant tissues are very susceptible to radiation and can be destroyed by half to one-fifth of the dosage necessary to destroy normal tissue, while glandular deposits are still more susceptible. Pre-operative radiation should be given in all cases and repeated post-operative radiation lessens the risk of recurrence.

(27) Radium Treatment of Carcinoma of the Eyelid.

Sanford Withers publishes the details of eight cases of carcinoma (rodent ulcer) of the eyelid cured by radium. (*Amer. Journ. of Ophthalm.*, January, 1921.) Rodent ulcer is the name usually given to this condition, and the success of the author, shown by the photographs which accompany the article, prove, in the author's opinion, that radium is the treatment of election in these cases. The details of the application in one case are given. Radium to the amount of 75 milligrammes in silver tube applications covered with 0.5 mm. of rubber, was applied for four hours. Nearly a month later 50 milligrammes were similarly applied. Two months later there was no sign of growth. There has been no recurrence during a period of three years. The total radium given was 500 milligramme-hours, averaging about 100 milligramme-hours for each square centimetre of the surface area of the tumour.

British Medical Association News.

TRANSACTIONS OF THE VICTORIAN BRANCH.

The following report is issued by the Council of the Victorian Branch for the information of its members:

Divisions.

The recommendation of the Organization Committee that the rules should be amended as regards the election by divisions of members of the Council for 1922 was adopted and a special meeting of the Branch will be called for August 3, 1921, to consider the proposals.

The proposed amendments will give three representatives to the Melbourne Division on account of the large number of members having their consulting rooms exclusively in that constituency.

A new Western District Division and a Gippsland Division have also been created with chairmen and honorary secretaries elected by the Council *pro tempore*.

Bush Nurses.

The question of bush nurses and their encroachment upon the domain of the medical practitioner has been before the Council for some months and conferences have been held with the Central Council of the Bush Nursing Association. A proposal of the latter that an additional representative of the Victorian Branch of the British Medical Association should be appointed has been accepted and Dr. J. H. Anderson has been asked to support Dr. H. Douglas Stephens, who is the present representative.

The Council of the Victorian Branch also forwarded a number of resolutions to the Central Council of the Bush Nursing Association, stating its attitude towards the bush nurse, *inter alia*:

(a) That the rule of the Bush Nursing Association that the services of the bush nurse should not be availed of by well-to-do patients, should be compiled with.

(b) The bush nurse should have a general as well as a midwifery training.

(c) Where there is a medical man in close proximity to a bush nurse, the nurse, even in trivial cases, should act only in association with the medical man.

The question of medical practitioners in bush nursing districts accepting seats on the local bush nursing council will be referred to the medical men concerned for consideration.

Roll of Honour.

The sum of £160 has now been received towards the proposed War Memorial.

"Speculum"

A reply was received from the Honorary Secretary of the Medical Students' Society, regretting the appearance of certain items in the *Speculum*. The issue had been withdrawn, and the Council of the Victorian Branch was asked to appoint a representative on the board of management of the magazine.

The Council, whilst desiring the success of the *Speculum*, considered that it should be a magazine managed by students alone and on that account it could not see its way clear to appoint a representative.

Herbalists.

Attention was drawn to a newspaper report of severe strictures passed by the Coroner upon the heartless conduct of a herbalist whose drugs had probably hastened the patient's death.

The Council had to reply to its informant that it was improbable in view of past experience that any redress could be obtained from the State Government.

The inaugural meeting of the Section of Preventive Medicine of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on June 29, 1921, Dr. R. H. J. Fetherston, the President, in the chair.

Dr. J. H. L. Cumpston and Dr. T. W. Sinclair read papers dealing with the scope in modern preventive medicine. Sir James Barrett, C.M.G., Dr. J. Newman Morris and Dr. R. H. J. Fetherston took part in the discussion. Many useful suggestions were offered regarding the future work of the Section. Dr. Vera Scantlebury has been appointed Honorary Secretary of the Section.

Miss Constance Brodribb Slater, M.B., 1903 (Univ. London), of St. James's Rectory, Croydon, has been nominated for election as a member of the New South Wales Branch.

David Adcock, Esq., M.B., Ch.M., 1920 (Univ. Sydney), of Guildford, has been elected as a member of the New South Wales Branch.

Notices.

The Scientific Committee of the Victorian Branch announces the following paper to be read at the meeting of the Branch in August, 1921:

August 3, 1921.—Mr. A. Fay Maclure, O.B.E.: Paper and Demonstration at the Alfred Hospital: "On the Making and Fitting of Modern Splints and Fracture Beds, Together with a Display of Splints."

Medical Societies.

THE MEDICAL SCIENCES CLUB.

A meeting of the Medical Sciences Club was held at the Adelaide University on May 6, 1921.

Professor F. Wood Jones exhibited casts of the face, head and upper part of the body of an Australian aboriginal. He drew attention to the necessity of losing no opportunity of obtaining casts of recently deceased aboriginals. Whereas in Europe it was possible to obtain casts of almost any other race of mankind, casts of the Australian aboriginal were unobtainable and this important type was therefore unrepresented in many museums and teaching collections. Professor Wood Jones urged medical men who had aboriginal patients under their care, to notify persons competent to make a cast immediately after the decease of such patients. The making of the cast involved no disfigurement and the expenditure of very little time.

Professor Wood Jones also exhibited a dissection, showing a supra-condylar process in relation to the adjacent soft parts. This was a relatively common abnormality in the white race of mankind, but was very rare in the negro, not having been found more frequently than three times in six thousand skeletons examined. It had never been described in the Australian aboriginal nor in any race of monkeys higher than the marmoset. It occurred only in the lower representatives of the higher orders of the mammals, but occurred invariably in the marsupials and in the reptiles. There was therefore in the supra-condylar process a very primitive character reappearing in the most advanced race of mankind.

Professor T. Brallsford Robertson exhibited a series of curves showing the effects of a low protein diet, a normal diet and the normal diet plus 0.6 gramme of dried thyroid tissue daily upon the urinary excretion of phenols in a subject having a high indican output and a phenol excretion three times the normal. The effect of the low protein diet was to diminish the phenol output but not nearly in the same proportion as the urea output, so that the ratio of phenols to urea or, in other words, the proportion of the protein intake which gave rise to putrefactive products, was actually increased by the low protein diet, doubtless owing to the imperfect assimilation and utilization of the vegetable proteins which formed the main source of protein in the low protein diet. At first sight, therefore, there was little advantage in employing a low protein diet. The advantage was clearly seen in the after effect, however, for on return to normal diet after a week on the low protein diet, the phenol output did not rise with the urea output, but only underwent a very gradual increase. The addition of 0.6 gramme a day of thyroid tissue to the normal diet produced, as might be expected, a large increase in urea output but a further fall in phenol output, which was probably attributable to more perfect assimilation and utilization of the proteins in the dietary.

Dr. F. H. Beare submitted diet tables from fifty cases of gastro-enteritis in infants. These tables showed that only twelve infants or 24% received cow's milk, fourteen were breast-fed throughout and the remainder fed on various

patent foods. Defects in the quality of cow's milk could not therefore have been responsible for the majority of these cases. Out of 36 cases in which the home surroundings had been inspected, however, in no less than 20 there were stables in the immediate vicinity of the house or a horse was kept in the back yard or in the neighbouring back yard and in these cases flies were very numerous. *Post mortem* examinations showed that fatty degeneration and congestion of the liver were a very regular accompaniment of gastro-enteritis proceeding to a fatal issue. Of the cases examined 80% showed this effect. Long-continued cases also revealed very extensive ulceration of the intestine. The spleen was normal.

Professor J. B. Cleland pointed out that the quality of cow's milk and bacterial changes in milk appeared to play a very small part in the production of diarrhoea and vomiting in children. If fed at the breast, they generally escaped, but upon any other diet there appeared to be considerable danger of the development of the disease.

Dr. H. Swift dwelt upon the danger of deficiency diseases arising from the prevalent use of artificial foods or of milk preparations dried at high temperatures and in contact with oxygen.

A discussion of the measures advisable to improve the quality of the milk supplied to Adelaide then followed. A number of the members participated.

Correspondence.

MODERN OBSTETRICS.

Sir: In her reply to my article on "The Case for Nature" Dr. McLorinan says that "on the question of normal labour, the views of Professor de Lee and Dr. Meyer are in complete variance." In the last edition of his "Principles and Practice of Obstetrics" (1920), Professor de Lee says in his introduction to the management of labour: "The duty of the accoucheur is to observe the efforts of Nature, not to aid, until she has proven herself unequal to the task. Only when Nature fails is art to enter. Nothing is so reprehensible as meddling midwifery. It has cost thousands of valuable lives."

In reviewing a paper by Ahlfield advocating the expectant treatment of the third stage, de Lee says: "The paper of Ahlfield is very timely. The accoucheur is too prone to hasten or attempt to hasten the third stage of labour. The placental stage requires more skill to conduct right than the other two stages combined and I believe more women die from mistakes made in the third stage than from those made in the two other stages."

And in the same annual review, speaking of "the danger threatening the mother from so much instrumentation," he says: "The child, too, is often lost in the attempt to save it. The indication to interfere in obstetric cases must yet—in spite of all our late improvements of technique—be drawn very carefully." If this does not mean that labour should be left to nature as much as possible, what does it mean? Such "governing principles" as these are far removed from a disregard of the physiological factor in labour; they carry with them the strong suggestion that "a masterly inactivity" is not incompatible with a well-fitted obstetric bag.

I do not accept Dr. McLorinan's dictum that obstetrics is an art and not a science. To do so would be to ignore its scientific development, since it was taken out of the empirical stage and placed upon an anatomical and physiological foundation. As Professor de Lee puts it: "The study of all the processes of reproduction, both normal and pathologic, is the science of obstetrics; the application of this scientific knowledge and that derived from intelligent experience at the bedside of the patient comprises the art."

It would be rash and unphilosophic to deny the possibility of light being thrown on obstetrical questions from a study of the comparative anatomy and parturition of the marsupialia. Perhaps Nature, who fulfils herself in many ways, may some day, as Dr. McLorinan hopes, disclose the reason why she has fixed a period of 275 days of intra-uterine life for the human foetus and 25 of that of the wombat. But meanwhile the period of gestation, as between woman

and wombat, does not appear from such evidence as we have to admit of a quantitative re-adjustment.

The main purpose of my article was a defence of Nature on a charge of operating destructively against the reproduction of the human species. It involved the refutation of a theory of evolution based upon a misconception of biological principles and it involved also a plea for the due recognition of and regard for the "natural" element in labour. This is the "case for Nature" as I conceived it. If it has any lesson at all for the student of obstetrics, it will not be labour in vain.

Yours, etc.,

FELIX MEYER.

Melbourne.

June 15, 1921.

THE VICTORIAN MENTAL HOSPITAL SERVICE.

Sir: As far as I can see the main reason for the unsatisfactory conditions as regards medical service is the fixation of salaries by men who know nothing of the medical work entailed. Unfortunately we have ourselves to blame to some extent. Lunacy was long regarded as an almost unwelcome addition to the family of medicine and it is only in the last few years that the enormous part played by the mind in all disease is coming to be understood. The attitude of the lay mind which regards lunacy as a stigma, helps to relegate it and all concerned with it to the limbo of forgotten things; and until recently the Association seemed to have been oblivious to our very existence.

No satisfaction can be expected until the Association determines what it considers a fair salary for every medical man employed in public services and insists on him getting it.

The Victorian Government is now advertising for whole time health officers (with a D.P.H.) and offers a maximum salary of £750 without any prospect of advancement. This represents a pre-war salary of £420—for a specialist! What prospect has it of getting the best men, when at the same time the Commonwealth determines to pay its health officers at the end of three years £798 with prospects of advancement to £1,100. A health officer in the Commonwealth service can attain a salary equal to the Victorian Medical Superintendent in three years as compared with an average of fifteen years. How can such anomalies be allowed? Our salaries are still the same as they have been for years before the war and they are likely to remain so, as justice seems unattainable by ordinary channels.

The knowledge that medical men will not desert their patients has been too long played upon. The Association should now exert its full pressure to have uniform salaries paid throughout the Commonwealth and the amount suggested by your correspondents is none too large. A united and determined front can force the hands of the various Governments as it did the lodges and the time is certainly opportune for such a movement.

Yours, etc.,

F. CATARINICH,
Medical Superintendent.

Hospital for Insane,
Beechworth,

June 23, 1921.

SPINAL ANALGESIA.

Sir: Dr. Silverton's article on spinal analgesia in your issues of the 11th and 18th June has been of particular interest to me.

It recalled my early enthusiasm for this method on account of the advantages which it presented and which Dr. Silverton describes.

My first experiences of this method were read before the Medical Society of Victoria on the 1st August, 1906, and appeared in the *Intercolonial Medical Journal of Australasia* of 20th August, 1906. But after using this method in about 500 cases I gradually discontinued its use and for over eight years have not had occasion to employ it.

There are two reasons for this change. One is the great safety of the anaesthesia obtained from ether administered by the open method. The other is the risk of upward

after-effects that may follow spinal analgesia in the way of headache and affections of nerves and spinal cord. The headache, though not frequent, was occasionally of the most severe and intractable character and one had no means of foretelling the likelihood or otherwise of its occurrence.

Though pareses and paralyses generally cleared up, I know of two cases where they have remained and caused disablement and one of these, unfortunately, is associated with urinary incontinence.

Both these cases gave a negative history as regards syphilitic infection and both were done before the Wassermann test had come into use. It is therefore of interest and no doubt has its practical bearing, that the Wassermann test has since proved both these patients syphilitic.

As a result of my experience I consider the risk of after-effects a much more serious disadvantage of spinal analgesia than is generally admitted by its advocates.

Yours, etc.,

B. T. ZWAR.

Collins Street, Melbourne,
June 20, 1921.

AS ANOTHER SAW US.

Sir: The aurists of which section of the profession I am a humble member, have not seldom "a guild combet" of themselves on what grounds their fellow practitioners may be allowed to judge.

Be that as it may, it is interesting to read what a distinguished surgeon thought of the craft in 1840.

Robert Liston, writing in his "Elements of Surgery," said of us ear specialists: "Such is the division of labour in these days that a distinct profession is founded on the operation of squirting water into the external ear. It is true that other operations are talked of by these aurists as they style themselves, but the advantage to be derived from any of them is often very doubtful. They talk of deafness as arising from a deficient secretion of cerumen, from dryness or from eruption in the meatus; and heating stimulant applications are poured in—oils, ointments, mercurial salts, acetic acid, garlic, etc., all combined. They even go so far as to recommend mercurials to correct the state of the general health and the digestive organs, upon the derangement of which, say they, many cases of deafness depend. The fools who apply to such charlatans, certainly deserve to have their pockets well drained, but ought scarcely to be poisoned by them."

I wonder has Robert Liston any successors!

Yours, etc.,

RICHARD ARTHUR.

Macquarie Street Sydney,
Undated.

MEDICAL ETIQUETTE.

Sir: After many years of general practice, it is with regret that I notice a growing retrograde change in certain matters of medical etiquette. When I commenced practice in the late 'seventies, some of the customs of the present day would have been thought very out of the way procedures and anyone practising them would have been considered as guilty of a breach of etiquette.

It is now-a-days a common thing for a medical man to encroach upon the district held by his neighbour, establishing a consulting room, with stated times of attendance and seeking to get a share of his appointments. To use a recently coined phrase, this is not "playing the game." In city practice it is difficult to avoid a certain amount of overlapping, but in country districts it is avoidable; in both instances it should be obviated so far as is possible.

In former times, if a medical man commenced practice in a township where another doctor had perhaps for some years been engaged, the recognized custom was for the newcomer to call upon the resident practitioner and explain that it was his intention to settle and practise in that place. I am afraid this act of courtesy is not now always adhered to.

The matter of correspondence is another thing about which practitioners should be scrupulous. I have myself experienced a lack of courtesy in this respect, letters concerning patients being unanswered.

When a patient desires the advice or attendance of a practitioner other than the usual attendant, the new consultant should make quite sure that the way is clear to enable him honourably to take over the case.

The due observance of these essentials would help to keep up the tone of our profession and would make for confidence and goodwill amongst its members.

Possibly the increasing numbers of young men qualifying for medical practice and the consequent difficulty in getting a start is to some extent responsible for the conditions mentioned, but it should be borne in mind that our calling is a beneficent profession and that its members are amenable to a code of ethics which should prevent it from drifting into a mere commercial enterprise.

Yours, etc.,

SENIOR.

THE WASSERMANN TEST.

Sir: The desirability of adopting a uniform technique for the performance of the Wassermann test is so obvious that I feel no apology is needed for voicing what appears to be a pressing need among serologists in Australia.

The introduction in the various Australian States of legislation dealing with venereal disease, providing as it does for free clinics and laboratory tests in connexion with venereal disease cases, together with the growing appreciation by the medical profession of the value of the test, will materially increase the amount of laboratory work in this connexion. In this State, where legislation for the control of venereal disease had its inception in Australia, the result has been, *inter alia*, an increase at least tenfold in the number of Wassermann tests performed annually.

With the interchange of patients from one clinic—and also from one State—to another, the necessity for all serologists to endeavour to work on lines which are uniform and reliable and therefore productive of uniformity of result, becomes apparent. Such uniformity is essential also for the valid judgement of the effects of various treatments on syphilis and on the Wassermann test. Lack of uniformity in technique and of uniformly standardized reagents, together with varying forms of notation for expressing results, lead to endless confusion and go far towards discrediting what should be a most useful aid to the syphilologist.

Moreover, as pointed out in the Report of the Medical Research Committee in England (Special Report Series, No. 14, issued 1918) since, in the absence of standardization the diagnostic value of the tests carried out by any given laboratory cannot be estimated either absolutely or in comparison with others performed elsewhere, the resulting uncertainties must render valueless for scientific statistical purposes the large volume of work from which information of great value might otherwise have been extracted.

Most serologists are doubtless cognizant of the important investigations recently carried out in London under Colonel Harrison's direction by Drs. Griffiths, Scott and Eastwood, an account of which was published last year in a report issued by the Ministry of Health (Reports on Public Health and Medical Subjects, No. 1, issued 1920). This research was inaugurated with a view to clearing up the difficulties which beset the Advisory Committee in their endeavours to lay down a standard technique for the test and which were voiced in the report of the Committee.

As a result of patient and systematic research a routine method has been formulated which the authors deem worthy of trial. The reasons underlying the elaboration of this method as given in the later report (1920) are, I think, sufficiently convincing to warrant an attempt being made to secure its adoption as a standard method for Australian laboratories.

I have personally been using this method for some little time and for purposes of comparison have also used two other methods (the number four method of the Advisory Committee's report, 1918, and a modification of Wassermann's original technique—both with and without ice-chest fixation). Though the number of comparative tests so made is not yet sufficiently large to admit of a definite conclusion, I have found on several occasions that the latest method—

that of Griffiths and Scott—is the more sensitive and has produced results more uniformly in keeping with the clinical aspects.

I would suggest that with a view to ultimately adopting a standard technique, a series of comparative tests be performed in each laboratory between the method of Griffiths and Scott and whatever method is in use in each laboratory—the results to be checked as far as possible by full clinical details. If all serologists were to co-operate in this way, sufficient data would soon be available and by the publication of such results and conference between workers, the relative importance to the test of points in which techniques differ, might be settled and a method adopted which would prove acceptable to all and be productive of uniformity of result.

The use of standardized reagents prepared in a central laboratory is essential for the success of any attempt at uniformity in technique. More especially does this apply in the case of "antigen" recommended by Griffiths and Scott. This latter is one in which the ratio of acetone-soluble to acetone-insoluble lipoids is determined by experiment, the object being to combine the two fractions in such proportion that the "adjuvant action of the acetone-soluble lipid (cholesterin) and the pure specific action of the acetone-insoluble fraction" are obtained, while at the same time the safety of the test is not diminished. The preparation and standardization of such an extract is beyond the scope of a laboratory where much routine work is performed. Further, since "antigens" prepared from the same materials by different workers are known to exhibit different behaviour, it is necessary, if comparative results are to be obtained, that such standardized "antigen" be issued from a central source. The co-operation of the Federal Department of Public Health in this direction would doubtless be possible by means of the Commonwealth Serum Laboratory.

The establishment of a central laboratory would be of further assistance in that sera giving doubtful reactions with various workers could be sent to it for further testing. It would also be useful if samples of sera giving certain reactions were circulated and used by different workers as standards by which to compare results. Even if the attempt to effect uniformity of technique failed, by adopting this latter suggestion of the exchange and circulation of samples of sera "a better idea would be obtained of the meanings of the results recorded by one observer when interpreted in the terms employed by others."

Many of the above suggestions I have taken from Colonel Harrison's introduction to the Ministry of Health Report. For their application to the various Australian laboratories further elaboration is necessary. But the question of their adoption might well be considered either along the lines I have indicated or along others which I hope those interested in the subject may contribute through your columns.

Yours, etc.,

CYRIL H. SHEARMAN.

Department of Public Health,
Perth,

June 22, 1921.

THE SHIBBOLETH OF THE X-RAY "SHADOW."

Sir: Dr. Nisbet, at the conclusion of his interesting paper on "Advances in Radiology" in your issue of June 25, directs attention to the statement one sees and hears repeated *ad nauseam*, viz., that, as radiologists, we must remember that "we are only dealing with shadows" and must recognize our consequent limitations.

Now, may I point out that it would be just as correct to be always insisting that, in ordinary vision, "we are dealing only with reflections," self-luminous objects alone excepted?

As a matter of fact, an X-ray plate is very much more than merely a collection of shadows. Viewed from the proper point it gives a correct monocular image of the object, as we would have seen it with the eye replacing the focal spot of the tube. There are two differences only: one, that the images of nearer objects (these being further from the recording plate) are less distinct than those of the more distant; and the other infinitely important one, that the object

is transparent, so that we can see its internal structure instead of merely its surface.

A single X-ray plate is thus of no more value looked at with two eyes than it is looked at with one, both retinæ receiving the same image. If we content ourselves with this single monocular view we must expect relatively no more information than we would get, in ordinary vision, were we to look at a strange object with one eye only instead of with the two with which Nature has endowed us.

That these observations are correct is shown at once by the fact that if we take a second view with the tube moved to correspond with the assumed position of a second X-ray eye and combine the two results stereoscopically, we get, following the psychical fusion of the two impressions in our brain, a perfect reproduction in three dimensions of the object viewed.

The point of the whole matter is that the images formed on our retinæ by the light transmitted through the X-ray plate play exactly the same part in our visual perception as do the retinal images formed in everyday life by the light reflected from the objects in our field of vision and that there is no more "limitation" in the one process than in the other.

Space forbids of one's demonstrating the matter more fully, but it is hoped that sufficient has been said to warrant the dropping of the oft-repeated phrase of "only shadows," as though this were some inherent, insurmountable defect in radiography.

Yours, etc.,

K. STUART CROSS.

Collins Street, Melbourne.

June 30, 1921.

WHERE IS TROPICAL AUSTRALIA?

Sir: Take the map of Queensland, locate Toowoomba and Charters Towers; through these points draw a line roughly parallel to the coast and less than 100 miles from it.

Through Camooweal (close to the Territory border and west of Townsville) draw a line parallel to this first line.

Through Georgetown draw a line parallel to the New South Wales-Queensland border.

We have here a parallelogram about 400,000 square miles in extent, embracing a wonderful country, comprising perhaps some of the best sheep and cattle country in the world.

Varying in height about sea-level from 500 feet to 1,800 feet, averaging, say, 800 feet, it possesses a magnificent winter climate from April to October, cold, sharp nights frequently below zero and clear, sparkling days unknown on the coast. From November to March the days vary from warm to devilish hot, but the nights are cool, the shade dry-bulb temperature going as high as 110° F. or higher, averaging, say, 95° F., but, and here is the whole crux of the situation, there is a wide variation between wet- and dry-bulb reading; the atmosphere is extremely dry.

The result is that evaporation from the body is so rapid that one is able on the hottest day to play a good, hard single game of tennis or do a hard day's manual toil in the sun in perfect comfort and enjoyment.

It is this wide variation between the dry and wet bulb temperatures that distinguishes a temperate from a tropic zone; and if someone would so delimit northern Australia, it would be found that tropical Australian almost didn't exist.

There is no difference between the climate of this vast area and the non-coastal portion of New South Wales. Today this area is slowly becoming peopled by a vigorous, hardy, prosperous and self-reliant race, marrying and producing healthy youngsters. As for the women, given anything like the home comforts in the matter of housing, water and food obtaining in the south, they can, and do, maintain their health.

None who have visited the Cloncurry mining field where the majority of the younger generation were born in Charters Towers, but are struck with the vigour and physique of their children, nor can their fecundity be questioned.

Those who have got beyond the coastal belt of Queensland, know that this is the promised land for the Anglo-Saxon who is not afraid to work.

Yours, etc.,

CLIF. TUCKER.

Brisbane,

June 13, 1921.

Books Received.

- A PRACTICAL MEDICAL DICTIONARY OF WORDS USED IN MEDICINE, WITH THEIR DERIVATION AND PRONUNCIATION, including Dental, Veterinary, Chemical, Botanical, Electrical, Life Insurance and other special terms; Anatomical Tables of the Titles in General Use and Those Sanctioned by the Basic Anatomical Convention; Pharmaceutical Preparations, Official in the U.S. and British Pharmacopœias and contained in the National Formulary; Chemical and Therapeutic information as to Mineral Springs of America and Europe and Comprehensive Lists of Synonyms, by Thomas Lathrop Stedman, A.M., M.D.; Sixth Revised Edition; Royal 8vo., pp. 1,144, with numerous Illustrations. Price, 42s. net.
- CHEMICAL REACTIONS AND THEIR EQUATIONS: A Guide and Reference Book for Students of Chemistry, by Ingo W. D. Hackh, Ph.C., A.B.; 1921. Philadelphia: P. Blakiston's Son & Company; Crown 8vo., pp. 138. Price, \$1.50 net.
- EXTRA PHARMACOPŒIA OF MARTINDALE AND WESTCOTT. Revised by W. Harrison Martindale, Ph.D., F.C.S., and W. Wynn Westcott, M.B., D.P.H., Vol. II., Seventeenth Edition; 1921. London: H. K. Lewis & Co., Ltd.; Foolscape 8vo., pp. 688. Price, 17s. 6d. net.
- ELECTROCULTURE: The Application of Electricity to Seeds in Vegetable Growing, by A. Carr Bennett; 1921. Sydney: Angus & Robertson, Ltd.; Crown 8vo., pp. 118, with 32 illustrations. Price, 5s. net.
- PRACTICAL CHEMICAL ANALYSIS OF BLOOD: A Book Designed as a Brief Survey of this Subject for Physicians and Laboratory Workers, by Victor Caryl Myers, M.A., Ph.D.; 1921. St. Louis: C. V. Mosby Company; Royal 8vo., pp. 121, illustrated by 13 figures. Price, \$5.00.

Medical Appointments.

The appointment of Dr. A. C. McArthur as Quarantine Officer at Grafton, New South Wales, has been approved.

Dr. W. J. Stack has been appointed Government Medical Officer at Molong, New South Wales.

The appointment is announced under the *Cattle Slaughtering and Diseased Animals and Meat Act, 1902*, of Dr. R. A. McWilliam Robinson (B.M.A.) as an Inspector at Tea Gardens, of Dr. E. N. B. Docker (B.M.A.) at Coonabarabran, of Dr. J. McBain Ross (B.M.A.) at Wilcannia and of Dr. William Beggs (B.M.A.) at Wauchope, New South Wales.

Dr. P. G. Clarke has been appointed Public Vaccinator at Rosedale and Dr. F. G. Morgan (B.M.A.) at the Commonwealth Serum Laboratories, Royal Park, Victoria.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xx.

University of Sydney: Professor of Psychiatry.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

- July 12.—N.S.W. Branch, B.M.A., Ethics Committee.
 July 12.—Tas. Branch, B.M.A.
 July 13.—Melb. Pædiatric Society (Vic.).
 July 14.—Vic. Branch, B.M.A., Council.
 July 19.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
 July 20.—Federal Committee of the B.M.A. in Australia.
 July 20.—W. Aust. Branch, B.M.A.
 July 22.—Q. Branch, B.M.A., Council.
 July 22.—Western Med. Assoc. (N.S.W.).
 July 26.—N.S.W. Branch, B.M.A.: Medical Politics Committee: Organization and Science Committee.
 July 27.—Vic. Branch, B.M.A., Council.
 July 28.—S. Aust. Branch, B.M.A.
 July 28.—Clinical Meeting at the Hospital for Sick Children, Brisbane.
 July 29.—N.S.W. Branch, B.M.A.
 Aug. 3.—Vic. Branch, B.M.A.
 Aug. 5.—Q. Branch, B.M.A.
 Aug. 9.—Tas. Branch, B.M.A.
 Aug. 9.—N.S.W. Branch, B.M.A., Ethics Committee.
 Aug. 10.—Melb. Pædiatric Society (Vic.).
 Aug. 11.—Vic. Branch, B.M.A., Council.
 Aug. 11.—Brisbane Hospital Clinical Society.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated. All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)